Symposium of the Reial Acadèmia de Medicina de Catalunya

CLINICAL COMPETENCE IN MEDICAL PRACTICE

Chaired by Dr. Jordi Sans-Sabrafen

ABSTRACTS AND CONCLUSIONS

Reial Acadèmia de Medicina de Catalunya
7 February, 1995

Published with the support of the
Departament de Sanitat i Seguretat Social
of the Generalitat de Catalunya

SOME FEATURES OF MEDICAL TRAINING IN THE ACQUISITION OF CLINICAL COMPETENCE

Ciril Rozman

SUMMARY. The concept of clinical competence refers to the quality of professional practice, that is, the quality of being a doctor. Since time immemorial our profession, it is insisted, has meant considerably more than the mathematical application of theoretical knowledge, and should combine the scientific bases with large proportions of the clinical art. Yet, there is no general agreement as to a definition of clinical competence. Here, the author propounds an integrated vision which combines technically correct behaviour with a morally accepted behaviour. Specifically, clinical competence means the acquisition and maintenance of a) sufficient scientific knowledge so that all activities have a rational foundation; b) the necessary skills for the practical application of this knowledge; c) the necessary attitudes for an integrated vision of the patient and their milieu, that is, within the psycho-social branches; d) the ethical qualities which motivate the will so that the capacity for technically correct behaviour is put into practice from a morally correct standpoint.

Various stages and features of medical training, necessary in guaranteeing the acquisition of clinical competence, are analysed. Undergraduate training needs to be restructured so as to take into account the interdisciplinary nature of the subject, furnish a problem-solving ability, and facilitate the acquisition of a range of skills and attitudes, such as active learning. Postgraduate training provides an opportunity for the acquisition of clinical competence, given that the student doctor is given an ever-increasing range of responsibilities, albeit under due supervision. Within this postgraduate stage of training it is necessary to introduce changes in the method of selection, the MIR (entrance exam for state health system), and guarantee entry into the profession to all graduates. Finally, the author examines certain features of continuing medical training which serve to up-date the clinical competence of the professional practitioner. This third stage of medical training, though, will only be entirely effective if and when undergraduate training meets both present and future needs.

EVALUATING CLINICAL COMPETENCE

Ramon Pujol-Farriols

SUMMARY. Evaluating the clinical competence (CC) of a doctor requires the definition of her professional quality on the basis of a fundamental body of knowledge and, in particular, her ability to utilise this knowledge in an efficient medical practice. In 1988, the Edinburgh Declaration, the basis for modern Medical Education, concluded: "Knowledge is fundamental, but so too should be the doctor's skills, attitudes and ethics so that in this way competence might pervade practice". Evaluation of CC should be an uninterrupted process beginning in the undergraduate years continued through postgraduate training and on into continuing education.

The benefits to be obtained from the application of CC evaluation systems are to be felt among the general public, in their role as receivers of medical care; among the profession; among those responsible for Medical Education; in the awarding of degrees and postgraduate certificates with real merit and among the administration of the health services. The influence of evaluation in education is paramount given that what is learnt is what is known to be evaluated.

There are many methods of CC evaluation available, leaving aside traditional oral examinations, multiple choice tests, global evaluation scales clinical history analyses, patient satisfaction and colleague assessments among others, in recent years simulations have been developed with standardised as well as computerised patients which have contributed a high degree of realism and are becoming more and more useful. One such test is the OSCE (Objective Structured Clinical Examination), which is now more than 20 years old and is used in more than 40 countries, and in which various methods of evaluation are combined. There are three conditions which a suitable test must fulfil: 1) validity, i.e. that it measures what it set out to measure, 2) applicability, i.e. that it can be applied under a variety of conditions, and 3) practicality, i.e. that its application is feasible.

While the most suitable way to determine a doctor's CC is to observe her in practice, the fact that it is impossible to universalise and standardise this type of analysis has given rise to an influx of new techniques, which if in addition to having a direct influence on training, might bring about a higher level of CC.

SOCIAL DEMANDS OF CLINICAL COMPETENCE: AN OBJECTIVE AND SUBJECTIVE PROCESS

Francesc Xavier Altarriba

SUMMARY. In medicine, clinical competence not only implies a mastering of the stock of technical requisites, offering reliable prognoses and administering suitable therapeutic techniques, providing proper rehabilitation and palliative treatment and bringing succour to the sick when recovery is no longer technically possible, but a whole series of features, outlined below, which take into account two facets of the concept of health: the magnitude of its nature and those effects which are both objective and subjective.

Bearing in mind that each age, on the basis of knowledge acquired and prevailing values, redefines the concept of health, then we might venture to define health as: That state in which man obtains maximum functional capacity, directed towards well-being, bearer of meaning, within a specific historical, geographical and socio-anthropological setting.

The magnitudinal nature of health and its bio-, psycho-, socio-anthropological essence, which interacts in an interdisciplinary and multiprofessional manner is significant, as is the existence of two major approaches: an objective-descriptive method and a subjective-interpretive method. The objective-descriptive method recognises those parameters which enable man to be described as healthy, that is, able to function. The subjective-interpretive method, on the other hand, refers to the concept of feeling well.

Clinical competence now needs to catch up with, and incorporate, aspects of basic science with those of applied science. Similarly, we feel that clinical competence needs a functional understanding of the existence of man as a dynamic equilibrium between health and sickness; founded on the genetic potential of the individual, on his capacity for adaptation and on the risk factors in his environment which influence his life style.

The knowledge underlying clinical competence has to be applied with a resolute predisposition, the fruit of one's vocation, personality, values and experience: what we would call attitude. Every trade or profession is based on the mastering of certain aptitudes and the application of certain attitudes. Attitudes in medicine are of great importance, we are after all working with human beings - structural and functional units which interact as integrated and dynamic systems with their environment.

In addition to the necessary apti-

tudes and suitable attitudes, the clinical competence of a doctor needs to incorporate a degree of skill in performing the job, which requires deftness, imagination, intuition and, on occasions, improvisation. As well as curing and rehabilitating, the doctor should be aware of his role in promoting health and palliative treatment. If we encourage the work in these two areas, in addition to reducing health care costs, we would considerably improve patient perception of comfort. As mentioned earlier, in order that the process of being healthy - experienced by the patient - is accompanied by a sense of feeling well, medicine will need to incorporate psycho-social and even sociological strategies. The achievement of such will require the inclusion of three concepts: social medicine (a part of preventive medicine, oriented towards the diagnosis and treatment of real illnesses, but which are frequently ignored by the patient), sociology of medicine (the study of the relationship between attitudes, roles, values and ideologies in the health field using a social methodology), and medical sociology (a concern for the specific problems in the medical and health environment in relation to the context in which they occur).

Clinical competence needs therefore, as a matter of course, to offer integrated, personalised and resolute health care to the individual and community in need. To achieve this, a global and unitarian knowledge of man needs to be incorporated in the training of would-be doctors, in an instructive and consummate manner.

Technical knowledge confers on the holder know-how, authority and power; but it is human contact which fosters trust, sincerity and a cooperative predisposition between the doctor and his patient. Values such as sincerity, truth and genuineness in the manner in which the doctor expresses diagnoses and prognoses to the patient or to the family, also form an important part of clinical competence.

In a near future of high technology, instrumental asepsis will produce the side-effect of fear and a growing detachment in the relationship between doctor and patient. This effect will need to be neutralised by bestowing on the doctor sufficient psychological and sociological resources in order that he might fulfil his treatment.

To conclude, integrated health care for the patient and the community needs to be provided from a bio-psycho-social perspective, given that man is an indivisible unit and that the parts should not be mistaken for the whole. The human body, in its widest sense, acts and responds as a system, open to the affects of biological, psychological and social inputs, as stimuli and responses as well as causes and effects in relation to the dynamic complex of the concept of health.

WHAT IT MEANS TO BE A DOCTOR

Gonçal Lloveras

SUMMARY. Pedro Laín explains that the cultural evolution of Medicine since the mid-nineteenth century has been a continuous attempt at offering a purely rational explanation of disease (causes and possible cures) from the perspective of naturalist positivism. Similarly, Comtian positivism considers the historical evolution of man as a process which develops through various stages: beginning at the theological, progressing through the metaphysical-philosophical, before entering the scientific stage. However, Nietzsche objected to such an interpretation of the world based as it was on "counting, measuring and weighing".

The debate is centuries old and in this time the role of the doctor has swung between the two extremes of the intellectual spectrum, so that the doctor has been considered successively: *a*) an expert in anatomical structure (who has sought an understanding of disease in external manifestations; the parts being more important than the whole); *b*) a scholar who has focused on functions (whereby external manifestations of disease have been considered secondary to physiopathological explanations), and *c*) an inventor and user of technology.

An explorer of the mind, whereby emotional alterations resulting in suffering or socially aberrant behaviour obtained intellectual respectability albeit on the periphery of science and technology. It was Freud's work which presented a new way of exploring the mind as a separate entity from the organism. Yet, it was not psychopathology, but medicine as a whole which was to demand for itself a cultural change, which has still to be fully assimilated as has been witnessed in the renewed debate as to how medicine might be best taught.

The fact remains though that as the patient is a human being and not a simple (complex) organism we are duty-bound to seek the introduction of certain fundamental characteristics within the Health Sciences so that we might gain a better understanding of the causes and evolution of disease.

Yet, such neo-humanism, as well as knowing how to ask questions, listen to and interpret the patient's replies, should know how to avoid excesses without overlooking equality; should remain faithful to the scientific vocation without unwittingly converting the patient into a mere object for study in order to enhance professional standing; and should be familiar with and

promote the use of technology, without letting this very technology dictate the philosophy. The cultural change should be seen as an intellectual challenge and not as a nostalgic hankering for the erstwhile doctor-patient relationship. For as Balint has pointed out, this relationship can be laden with profligacy: 1) either through an excess or lack of affectivity (uncontrolled and abusive intensification of transference; doctor's emotional indifference: adoption of attitude of public sector worker or one of scientific detachment; apostolic attitude imposing criteria of happiness; seductive professional image abusing social standing and abrogation of the patient's (or society's) critical sense), and 2) Ill-disposed affectivity (excessive greed; by-products: strategic smiling, aesthetics, advertising).

Being a doctor means: having a love of research, without excessive ingenuousness; biologically, studying the parts without overlooking the whole; not leaving psychosocial factors of human disease in the hands of radical spiritualists, and adapting its deontology to a renewed ethic. In 1911, the poet Joan Maragall forewarned: "We should strive to use the body as soul and the soul as body".

CLINICAL COMPETENCE IN MEDICAL PRACTICE: SUMMARY AND CONCLUSIONS

ordi Sans-Sabrafen

It gives me great pleasure, as organ-ser of this symposium, to express my sincerest thanks to all participants for heir highly stimulating contributions. I oelieve that today we have fully com-olied with the objectives of *Reial Acadèmia de Medicina de Catalunya* o provide a forum in which basic ssues of professional practice can be debated.

As was mentioned in the introduc-ion, for many years the teaching of Medicine in our country has given scant regard to the importance of prov-ding the undergraduate student with an adequate level of clinical compet-ence. Our faculties have given priority o a theoretical education; though, what might be deemed more repre-ensible is the fact that it would seem nsufficient attention has been given to ensuring the medical student grad-uates knowing how to "be a doctor", having learnt, for example, the appli-cation of common sense, among many other subjects, to professional prac-tice.

In this symposium we have been able to confirm that, while these inad-equacies persisted, there were profess-ional practitioners who had not only identified them, but who at the same time were working to construct the sound foundations on which radical reform in the future teaching of Medi-cine might be constructed. Having list-ened to the papers presented within this symposium, it appears obvious that this fundamentally conceptual change is being carried out effectively. It is also clear that within the next few years, we will have a new model of undergraduate teaching. But, in order for that to be feasible, the MIR (ent-rance into state health system) evaluation method will have to be modified. Since, as Dr. Rozman says, while the MIR system has been the most important educational contribution to Spanish medicine in the last twenty years, the entrance examination does not consi-der the global training needed by a doctor. The student becomes obsessed with passing an exam which solely evaluates knowledge and which, more-over, demands a disproportionate erudition. This distorts his motivation, which becomes focused on the prim-acy of storing knowledge, relegating to second place what is, quite simply, of greatest importance - being, first and foremost, a good general practitioner

with an adequate command of the so-called clinical competence.

Dr. Pujol Farriols has informed us of the existence of valid, applicable and practical methods for evaluating this type of training and which will, undoubtedly, enable us to make substantial changes in the content of the present MIR examination. It is further evident that this new form of education will mean that the doctor trained in active learning will be better prepared to follow a programme of continuing education, enabling him to maintain the required level of clinical competence throughout his career.

The professional, trained in accordance with these new methods, will be better adapted to the needs of our society, which, as Dr. Altarriba points out, requires a doctor, who while possessing the necessary knowledge and adequate control of technology, also respects the man as an indivisible unit in all his experiential and social complexity. A doctor who, according to Dr. Lloveras, studies the parts without overlooking the whole - the "human" doctor described by Dr. Gol, who, within the confines of a strict code of practice, realises that medicine is, both a science and an art form and that its practice requires an important degree of humanity.

To conclude, I would like to reflect on the importance that symbolic acts might have in raising the awareness of recent graduates to the noble mission they must undertake in society. I refer to the taking of the Hippocratic oath, not only as a simple ceremony but as a solemn, binding act which should remind them of their moral obligations - the ethical responsibility which requires of them the same degree of dignity as their august calling.